TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Surgical Hospital

Respondent Name
Merged Connecticut Indemnity Co

MFDR Tracking Number
M4-16-3674-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
August 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original billing was submitted in a timely fashion and denied as a duplicate with no further explanation offered. Our office received a request for a report which was sent on 02-10-2016. On 06-24-2016 our office was advised to submit a reconsideration. The response to our reconsideration was a denial based on timely filing which was an erroneous denial."

Amount in Dispute: $1,118.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are attaching another EOB for your consideration and review."

Response Submitted by: Cunningham Lindsey

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2016	Outpatient hospital services	$1,118.88	$1,118.88

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
3. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired

- 16 – A report must be submitted and/or was not included with the billing

Issues

1. Is the carrier's denial supported?
2. What is the applicable rule that pertains to reimbursement?
3. How is the maximum allowable reimbursement calculated?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks reimbursement of $1,118.88 for outpatient hospital services rendered on January 4, 2016.

   The insurance carrier denied the disputed services with reduction codes, 16 – "A report must be submitted and/or was not included with the billing," and 29 – "The time limit for filing has expired."

   The above denials are related to Medical Bill Submission by Health Provider regulations found in 28 Texas Administrative Code §133.20 (b) which states in pertinent part,

   > Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

   Review of the submitted documentation finds the carrier adjudicated the submitted claim on January 25, 2016. This claim denied for lack of documentation.

   The carrier processed the reconsideration request on June 30, 2016 and denied for timely filing.

   The Division finds the health care provider did submit the original claim timely therefore the services in dispute will be reviewed per applicable rules and fee guidelines.

2. The Division finds that the outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

The resources that define the components used to calculate the Medicare payment for OPPS are found below:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
  - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

The reimbursement of the services in dispute is calculated below.

3. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
> >
> > (A) 200 percent;

The reimbursement calculations is as follows:

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.9572	40% non-labor related	Payment Calculation	Maximum allowable reimbursement
96374	5693	S	$92.40	$92.40 X 60 % = $55.44	$55.44 X 0.9572 = $53.07	$92.40 X 40% = $36.96	$53.07 + $36.96 = $90.03	$90.03 X 200% = $180.06
96375	5692	S	$42.31	$42.31 X 60 % = $25.39	$25.39 X 0.9572 = $24.30	$42.31 X 40% = $16.92	$24.30 + $16.92 = $41.22	$41.22 X 200% = $82.44 units = $247.32
72131	5570	Q3	$112.49	$112.49 X 60 % = $67.49	$67.49 X 0.9572 = $64.60	$112.49 X 40% = $45.00	$64.60 + $45.00 = $109.60	$109.60 X 200% = $219.20
99284	5024	J2	$326.99	$326.99 X 60 % = $196.19	$196.19 X 0.9572 = $187.79	$326.99 X 40% = $130.80	$187.79 + $130.80 = $318.59	$318.59 X 200% = $637.18
							Total	$1,283.76

The remaining services in dispute have the following status indicators:

- Procedure code 96376 has status indicator N denoting packaged codes with no separate payment.
- Procedure code 80053 has status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3."
- Procedure code 85025 has status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3."
- Procedure code J1170 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J1885 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2550 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2930 has status indicator N denoting packaged codes with no separate payment.

4. The total allowable reimbursement for the services in dispute is $1,283.76. The requestor is seeking reimbursement for $1,118.88. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,118.88.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,118.88, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November 1, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.